STATE OF IDAHO HIV/AIDS Case Management Standards
Psychosocial Assessment Form

Intake Date Assessment Date Update Date Client ID

DEMOGRAPHICS

Clients Gender
O Male
O Female

Age_____

DOB____/____/_____

Race
O White
O Black
O Asian/Pacific Islander
O Native American/American Indian
O Other/Unreported

Ethnicity
O Non-Hispanic
O Hispanic

Veteran Status_____

Military Branch_____

Dates of Service_____

Insurance Coverage
O Private
O Medicaid
O Medicare
O VA
O Uninsured
O Other_____

HEALTH PROVIDER INFORMATION

Health Insurance Provider_____

Group Number_____ Member ID_____ Phone_____

Prescription Coverage Pharmacy_____ Phone_____
O Yes O No

Case Manager_____

Primary Care Provider_____ Phone_____

Address_____

Previous Medical Provider_____ Phone_____

HIV Specialist_____ Phone_____

Address_____

Dentist_____ Phone_____

Address_____

Psychiatrist_____ Phone_____

Address_____

Other Providers_____ Phone_____

EDUCATION / EMPLOYMENT / FINANCIAL INFORMATION

Education
O 8th grade or less
O Some HS
O Finished HS
O GED
O Some college

Employment
O Full time
O Part time
O Disabled
O Unemployed, looking for work
O Unemployed, not looking for work

Level of Satisfaction
O Not at all
O Slightly
O Moderately
O Considerably
O Extremely

Does client want to change his/her employment situation? O Yes O No
If yes, explain_____

Does client have any concerns about credit history or debt? O Yes O No
If yes, explain_____

Annual Income $_____ **Primary Source** _____

Other Resources $_____ **Source**_____

BASIC NEEDS ASSESSMENT
O Client is lacking resources to provide for basic needs (food, shelter, clothing). Immediate intervention is needed.
O Client has some resources to provide for basic needs; however, these resources are inadequate. There is a need for intervention, but the need is not critical.
O Client has adequate resources to provide for needs. There is no need for intervention.

LIVING ARRANGEMENTS

Does client currently have stable housing? O Yes O No If yes, O Permanent O Temporary

Type of Housing
O House (Rent/Own)
O Apartment
O Healthcare facility
O Correctional facility
Monthly Housing Payment_____

Living Arrangements
O Lives alone
O Lives with spouse/partner
O Lives with spouse/partner & family
O Lives with friends

Level of satisfaction
O Not at all
O Moderately
O Considerably
O Extremely

Information about persons living with client in the home:

_____ Permission to Contact: O Y O N
Name Relation

_____ Permission to Contact: O Y O N
Name Relation

Are there any environmental conditions that need to be addressed for the client's health and safety? O Y O N
If yes, explain_____

Does the client want to change his/her living situation? O Y O N
If yes, explain_____

LIVING ARRANGEMENT ASSESSMENT
O Situation is unsafe, and/or unacceptable to the client. Immediate intervention is needed.
O Situation is not permanent or not acceptable to the client. There is a need for intervention, but the need is not critical.
O Situation is stable and acceptable to the client. There is no need for intervention.

CHILDREN/DEPENDENTS

Total Number of Dependents_____

Who is responsible for care if client is not available?
O Spouse O Relative_____
O Guardian O Other_____
O Partner

Children/Dependents Name	Age	Relationship	HIV Status	Live In
				O Y O N
				O Y O N
				O Y O N
				O Y O N

Does client have guardianship arrangements made for the children/dependents? O Yes O No
If yes: Name_____ Address_____ Phone_____

CHILDREN/DEPENDENTS ASSESSMENT

O Client believes the living situation is unsafe, and/or inadequate for the children/dependents. Immediate intervention is needed.
O Client believes the living situation is inadequate, but not unsafe for the children/dependents. There is a need for intervention, but the need is not critical.
O Client believes the living situation is acceptable for the children/dependents. There is no need for intervention.

SOCIAL SUPPORT INFORMATION

Evaluate the strength of the client's social support system. 1= significant support 2= occasional support 3= weak support NA= support is not available

Spouse	?	Partner	?	Parent	?	Child	?
Sibling/relative	?	Friends	?	Support Group	?	Guardian	?
Church	?	Pets	?	Hospice Staff	?	Other	?

Level of satisfaction

O Not at all
O Slightly
O Moderately
O Considerably
O Extremely

SOCIAL SUPPORT ASSESSMENT

O Client appears to be isolated and lacking in any significant, reliable source of social support. Client feels the need for support. Immediate intervention is needed.
O Client appears to be lacking in any significant sources of social support, but seems comfortable with the situation. Intervention may be explored at a later time.
O Client has support, but feels the need for more resources. This may be explored more fully.
O Client has an active, acceptable social support network. There is no need for intervention.

MEDICAL INFORMATION

Date of HIV diagnosis_____ Location of HIV diagnosis_____

Any past opportunistic infections? O Yes O No
If yes, list:

Type	Date

Presently on HIV medications? O Yes O No
If yes, list:

DATE	MARK IF CURRENT	GENERIC	BRAND	DOSE	TIMES
Nucleoside Analog Reverse Transcriptase Inhibitors (Nucleoside Analogs, NRTIs)					
		Zidovudine (AZT or ZVD)	Retrovir		
		Lamivudine (3TC)	Epivir		
		AZT + 3TC	Combivir		
		Didanosine (ddI)	Videx		
		Zalcitabine (ddC)	Hivid		
		Stavudine (d4T)	Zerit		
		Abacavir (ABC)	Ziagen		
		ABC + 3TC + AZT	Trizivir		
Protease Inhibitors (PIs)					
		Amprenavir	Agenerase		
		Indinavir	Crixivan		
		Lopinavir (ABT-378/r)	Kaletra		
		Nelfinavir	Viracept		
		Ritonavir	Norvir		
		Saquinavir	Fortovase		
Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)					
		Delavirdine	Rescriptor		
		Efavirenz	Sustiva		
		Nevirapine	Viramune		
Nucleotide Reverse Transcriptase Inhibitors					
		Tenofovir	Viread		
Ribonucleotide Reductase Inhibitors					
		Hydroxyruea	Hydrea		

OTHER SCHEDULED MEDS AND PRN MEDICATIONS (*including OTC and nutritional/herbals)*

DATE	NAME	STRENGTH	DIRECTIONS	DATE DC'd

Health Status

Any weight loss?	O Yes	O No	Normal weight_____ Current weight_____
Any other chronic/ongoing medical problems?	O Yes	O No	Specify:_____
Any other health concerns?	O Yes	O No	Specify:_____
Is your appetite:	O Good	O Poor	
Who primarily prepares food in household?	O Self	O Other_____	
Does client want to change any aspect of his/her medical services?	O Yes	O No	

Level of satisfaction

O Not at all
O Slightly
O Moderately
O Considerably
O Extremely

MEDICAL ASSESSMENT

O Client has critical, unmet medical needs. Immediate intervention is needed.
O Client has unmet medical needs, but they are not critical. There is a need for intervention, but the need is not immediate at this time.
O Client does not have unmet medical needs. No need for intervention at this time.

MENTAL HEALTH INFORMATION

If any of the following questions are answered "No" and client/significant other reports memory loss, refer to psychiatric evaluation.

Does client know where he/she is? O Yes O No Does client know why he/she is here? O Yes O No
Does client know today's date? O Yes O No

Are any of the following a problem to the client?

Depression	O Yes O No	Anxiety	O Yes O No
Insomnia	O Yes O No	Forgetfulness	O Yes O No
Suicidal thoughts	O Yes O No	Delusional	O Yes O No
Dementia	O Yes O No	Withdrawal/Isolations	O Yes O No

How troubled has the client been with mental health problems in the past 6 months?
O Not at all
O Slightly
O Considerably
O Moderately
O Extremely

Any current mental health treatment? O Yes O No
If yes, specify provider, facility, diagnosis, and medications:

_____
_____

Prior mental health treatment: O Yes O No
If yes, specify provider, facility, diagnosis, and medications:

_____
_____

MENTAL HEALTH ASSESSMENT

O Client is in immediate need of psychiatric evaluation.
O Client is in need of psychiatric intervention, but the situation is not critical.
O Client may need psychiatric intervention at a later day, but presently is functioning well within the supports available.
O Client is coping well. There is no need for intervention at this time.

SUBSTANCE USE INFORMATION

Current substance use:
O Currently using
O Not using, in recovery
O Not using, not in recovery
O Never used

Does client identify drugs/alcohol as a problem? O Yes O No
Does significant other/family identify drugs/alcohol as a problem? O Yes O No
Has client had previous substance abuse treatment? O Yes O No
If yes to prior treatment, specify:_____
_____

If using:

Drug of choice	Amount/Frequency
1.	
2.	
3.	

SUBSTANCE USE ASSESSMENT

O Client is currently using drugs/alcohol but does not feel treatment is necessary and is not interested in obtaining treatment.
O Client is currently using drugs/alcohol and is interested in obtaining treatment.
O Client is currently in treatment.
O Client is currently not using drugs.

LEGAL INFORMATION

Does client need assistance with the following legal issues?

Guardianship O Yes O No
Living will O Yes O No
Power of attorney O Yes O No

Has client ever been convicted of civil or criminal charges? O Yes O No
Does client have any court cases pending? O Yes O No
Is client on probation or parole? O Yes O No

LEGAL ASSESSMENT

O Client needs assistance with several legal issues. Immediate intervention is needed.
O Client needs assistance with legal issues within the next month.
O Client may need legal assistance in the future.
O Client has no legal needs at this time.

INDEPENDENT LIVING SKILLS

Does client need assistance with any of the following daily activities?

Feeding	O Yes O No	Cooking	O Yes O No
Bathing	O Yes O No	Medication	O Yes O No
Walking	O Yes O No	Cleaning	O Yes O No
Dressing	O Yes O No	Finances	O Yes O No
Toileting	O Yes O No	Shopping	O Yes O No

Is assistance already provided for any of these items? O Yes O No

INDEPENDENT LIVING ASSESSMENT

O Client needs assistance with many basic functions. He/She is not able to continue living independently. Immediate intervention is needed.
O Client needs assistance with many basic functions, but can manage with in-home help.
O Client needs some assistance, but is still able to manage with support services and assistance.
O Client is able to live independently.

HIV BACKGROUND AND PREVENTION EDUCATION INFORMATION

Indicate mode of transmission: O MSM O Heterosexual contact O Prenatal
O IDU O IDU/ MSM O Hemophilia
O Transfusion O Other_____ O Unknown

Has client been sexually active in the past 12 months? O Yes O No
O Anal O Oral O Vaginal

Number of partners in the past year? O 0 O 1 O 2-3 O 4-10 O 10+
O Same sex O Other sex O Both sexes

In the last year has the client ever been worried that he/she might have gotten a sexually transmitted infection? O Yes O No
If yes, did they get it checked out? O Yes O No
What was the result? _____

Do you use protection? O Yes O No
What percentage of the time do you use protection? _____

Have you ever shared needles? O Yes O No

Are there things about reducing your risk you would like to know more about? O Yes O No
If yes, what are they? _____

Is there anything about safer practices that you would like to know more about? O Yes O No
If yes, what are they? _____

Do you feel comfortable disclosing your status to your partner(s)? O Yes O No

Do you feel responsible in preventing the transmission of HIV? O Yes O No

HIV EDUCATION ASSESSMENT

O Client has minimal to no knowledge of HIV/AIDS and puts self/others at risk. Immediate intervention is needed.
O Client has minimal knowledge of HIV/AIDS, but is not an immediate risk to self/others. There is need for prevention education at some point, but the need is not critical.
O Client has adequate knowledge of HIV/AIDS, no intervention is needed.

***If client responds yes to any of the bolded questions they should be considered for PCM. If client declines participation or provider decides not to pursue PCM with client, explanation must be documented in notes.*

TRANSPORTATION

Does client have own transportation? O Yes O No
Does client have access to and funds for public transportation? O Yes O No
Does client need specially arranged transportation through Title III or Medicaid? O Yes O No
Does client need other transportation arrangements? O Yes O No
If yes, specify:_____

TRANSPORTATION ASSESSMENT

O Client lacks resources and needs specially arranged transportation through Title 3.
O Client has Medicaid and needs specially arranged transportation.
O Client has adequate transportation for most needs but may need occasionally assistance.
O Client has adequate transportation.

DRUG ADHERENCE INFORMATION

MEDICATIONS Is client currently taking meds? O Yes	O Sometimes	O No
O Manages own meds	O Taking HIV meds but having problems	O Wants to start meds
O Reports missed doses		O Not recommended by provider at this time
Further intervention needed? O Yes O No		O Thinking about starting meds
		O Does not want to take HIV meds

Is client responsible for setting up own medication? O Yes O No
If no, who would assist? _____

Client understanding of medication:
O Thorough O Average O Basic O Confused

Are medications properly stored? O Yes O No
Are bottles in childproof containers? O Yes O No
Are bottles easy to open? O Yes O No
Are meds outdated? O Yes O No
Prescribed by multiple physicians? O Yes O No
Is visual dosage chart used? O Yes O No
Has client ever "borrowed" medications from another person? O Yes O No
If yes, how many times? _____
Who is responsible for ordering refills? O Self and/or_____
Who picks up refills? O Self and/or_____
Pharmacies used:_____
Prescriptions refilled by: O Pharmacy O Mail O Physician

Client Daily Living Style

Are meds taken on schedule every day/every time? O Yes O No
Number of doses taken late in last week? _____

Has client missed doses? O Yes O No
If so, how many times in the past week? _____

Is client a MORNING or AFTERNOON person? O am O pm

Is medical provider aware of adherence problems? O Yes O No

What complementary therapies does the client use? _____
_____

Is the medical provider aware of complementary therapies? O Yes O No

Does client eat: O Breakfast O Lunch O Dinner O Snack
Is water taken with meds? O Yes O No O Other

Is client having any side effects from taking the medications? O Yes O No
O Dizziness O Nausea O Rash O Diarrhea O Drowsiness O Headache O Other_____

Contraindications_____

Medical Provider notified? Date_____ Time_____
Pharmacy contacted? Date_____ Time_____

Barriers

O Depression/mental health
O Works outside the home
O Alcohol and drug use/abuse
O Complex medication regimen
O Care giving responsibilities
O Difficulty getting refills
O Lack of regular schedule
O Taste of medication
O Number of pills
O Undisclosed HIV status
O Side effects
O Lack of information
O Mental status changes
O Lack of social support
O Doubts medication effectiveness
O Needs assistance with ADL's (activities of daily living)
O Size of pills

DRUG ADHERENCE ASSESSMENT

O Client lacks understanding of medication regimen and has several barriers which make adherence difficult. Immediate intervention is needed.
O Client has minimal understanding of medication regimen and some barriers which make adherence more difficult to manage. There is a need for intervention within the month.
O Client has adequate understanding and support to maintain medication adherence. No intervention is needed.

ACTION STEPS

Education/Employment
Living Arrangements
Children/Dependents
Social Support Systems
Medical
Mental Health
Substance Use
Legal
Independent Living Skills

HIV Prevention Education
Transportation
Drug Adherence